

# Psychiatry and Psychotherapy

## Is a Divorce Imminent?

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*Despite the long tradition of psychiatrists practicing psychotherapy, many psychiatric and medical leaders are predicting and urging a reorientation of psychiatry toward the medical model. They would leave psychotherapy to psychologists, social workers and the like. Many social, governmental and institutional factors favor such a change. The marriage of psychiatry and psychotherapy has always been an uneasy one, and the push for divorce may be irresistible. The author cautions that a divorce could be detrimental to medicine by substituting, in the name of "science," a dehumanized, technological psychiatry for the current "moral" treatment. One alternative to divorce is a broader approach to psychiatry, combining biological, neuromedical, socioenvironmental and psychodynamic factors. The divorce, though imminent, should be resisted.*

PSYCHIATRY, the branch of medicine concerned with disorders of the mind, has for many years utilized psychotherapy as a principal treatment tool. This has been especially true in the United States, where Freudian teaching has been popular and the psychodynamic principles derived therefrom widely used. Various types of psychotherapy exist. They share in common interpersonal interaction between a healer and a patient, they pay particular attention to social, environmental and intrapsychic issues, and they utilize techniques

such as suggestion, hypnosis and psychoanalysis aimed at the patient's mind. The psychotherapies are distinct from the somatherapies—such as drugs and electroconvulsive treatment—in which attempts are made to alleviate mental symptoms using the biological and chemical soma.

Psychotherapy has become so much a part of American psychiatry that, for many, the two terms have become almost synonymous. Their modern marriage, begun in the 19th century and brought to fruition by Sigmund Freud, consequently has become a veritable fusion. A great proportion of office and hospital psychiatry involves psychotherapy, and psychotherapy continues to be a major pillar of many training programs. Therefore, the thought of psychiatry divorcing from psychotherapy is foreign to many

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psychiatrists—if not absurd. Nonetheless, the question of whether or not psychiatrists should continue to learn and carry out psychotherapy is currently a much discussed issue in psychiatric circles. Many in psychiatry are pushing hard for a divorce. Should such a change come about, the results would affect the entire realm of medical practice. Therefore, it behooves us to become familiar with the arguments, pro and con.

### **The Argument for Divorce**

In 1973 L. J. West<sup>1</sup> wrote an article entitled "The Future of Psychiatric Education." In it he predicted that by 1984 most psychotherapy will be done by social workers and psychologists and much of today's office psychiatry by family practitioners and internists. Although he warns against losing the "expertise in psychodynamics accumulated over the past 90 years," he nonetheless sees future psychiatrists as much more of neurologists, endocrinologists and behavioral scientists than their predecessors. West feels that future psychiatrists will also be teachers for, and provide liaison to, many medical and mental health disciplines.

Several economic factors add credence to West's predictions regarding psychotherapy. First, psychiatrists are physicians. As such, they are very expensive. Jerome Frank<sup>2</sup> has pointed out that no type of psychotherapist or psychotherapy has ever been proven better than any other. Therefore, one might ask, because social workers and psychologists generally charge lower fees than psychiatrists, why not send patients to them? Certainly, the planners of national health insurance might feel this way, as might patients unable to afford a psychiatrist's fee. In short, increased governmental and economic pressures, coupled with a growing need within medicine itself for the scientific and medical expertise which only a physician-psychiatrist can give, might well push psychiatry in the direction West predicts.

Bertram Brown,<sup>3</sup> former Director of the National Institute of Mental Health, has written that, in his opinion, the era of the analyst and dynamicist in psychiatry appears to be over and the era of the biological psychiatrist is upon us. Brown asserts that during the past 20 years most advances in the field of psychiatry have been in pharmacology, biology and the treatment of psychoses—not in psychotherapy. The biological psychiatrists, he stated, are the change agents of today's psychiatry. Thomas Hackett,<sup>4</sup> Massachu-

setts General Hospital's Chairman of Psychiatry, goes a step further: "Unless we are at home in medicine, psychiatry is homeless." He feels that, apart from their medical training, psychiatrists have little more to offer to patients than clergymen, social workers and lay therapists. Psychotherapy is currently fragmented into many factions and schools, and he warns that if psychiatry does not get out of psychotherapy and back into medicine, we are, in his words, "an endangered species."

Eaton and Goldstein<sup>5</sup> have indicated that the functional egalitarianism engendered by multidisciplinary sharing of psychotherapy has blurred the boundaries between psychiatry and the other mental health fields. As a result, perhaps, the general public no longer values the unique entity we call psychiatry. They point out that the result has been a substantial decline over the past ten years in federal dollars available for psychiatric education, as well as a considerable decrease in the percentage of American medical school graduates entering psychiatry. Perhaps, then, Hackett is right. Certainly, many American medical schools have recently seen within their own psychiatry departments a shift away from psychodynamics into biological psychiatry and other nonanalytic fields. Perhaps the leading edge of this change has been the Department of Psychiatry of the Washington University in St. Louis, where research into psychiatric nomenclature has led the American Psychiatric Association to consider sweeping changes in basic psychiatric diagnosis, putting psychiatry more squarely within a medical model: a model, one might add, not dissimilar to European—and, most notably, British—psychiatry. Although the researchers do not necessarily recommend divorce from psychotherapy, changes often go further than the research that began them had envisioned. Consequently, psychiatry, for all the reasons stated above, may indeed be on the brink of divorce from psychotherapy.

### **The Argument Against Divorce**

The marriage between psychiatry and psychotherapy has always been an uneasy one. Descriptive psychiatry, personified by Kraepelin, has often been at odds with dynamic psychiatry, personified by Freud. Psychotherapy is not at all easy to do, because, as Greenblatt<sup>6</sup> has pointed out, it is very difficult for a person to learn how to deal with the deepest feelings of patients. Descriptive psychiatry, in that sense, is much

easier to do, as it places less emotional strain on the therapist. Both Greenblatt<sup>6</sup> and Sederer<sup>7</sup> have traced the roots of "moral" psychotherapy from the French Revolution into mid-19th century America. Without the use of somatic treatment and using only interpersonal, social and environmental therapies, the Worcester State Hospital, leading purveyor of moral treatment, had a 70 percent cure rate. However, in the late 19th century, three factors put a strain on this moral treatment: the rise of scientific neurology and the belief that madness was due to specific brain damage, Darwin's theory which worked against salvaging "the weak," and a huge influx of patients which overwhelmed mental hospitals in the United States.

Sederer<sup>7</sup> finds similarities between late 19th century and current American psychiatry. When overwhelmed by sheer numbers, rising costs and diminishing funds, we may focus on neurology to do *something*, because we no longer have adequate staff to carry out moral treatments. "This type of solution to the pressure of practice has the aura of science . . . that some feel gives psychiatry a medical flavor," he stated. To do psychotherapy, he asserted, one needs warmth, genuineness and empathy, which create a relationship that allows a patient to relate his most intimate feelings and thoughts, something far deeper and requiring more therapeutic skill than that needed to obtain a history and physical examination. He agreed with Greenblatt that moral treatment, psychotherapy, is very hard to do, and felt that the medical model is very seductive, especially to medical students and junior trainees, because it involves much less personal anxiety on a therapist's part. Since biological treatment is cheaper than psychotherapy and places less emphasis on patients' responsibilities to participate in their own cure, and tends to treat patients like infants, biological psychiatry is also easier on all other concerned parties. Therefore, he argued, with more and more Americans demanding psychiatric care, with the increased need for psychiatric consultation within the medical setting, and with the rising cost of health care, the tendency, should psychiatrists ever stop practicing and learning psychotherapy, will be for the separation to perpetuate itself. Once divorced, he feels, these factors will perpetuate a permanent schism.

Sederer asserted that science is a form of humanism, but "scientism," the cult of science that worships technology for its own sake, is unidi-

mensional and antihumanistic. It reduces man to a mechanistic, concrete, nonindividual entity. Quoting Sir William Osler, he stated the following: "The human heart has a hidden want which science cannot supply." He argued forcibly that without psychotherapy psychiatry is "just like the rest of medicine," with nothing unique or special to offer patients. He warns against throwing out psychotherapy the way our 19th century predecessors discarded moral treatment.

Brown<sup>3</sup> pointed out another reason to continue to do psychotherapy: consumerism. He alleged that, as in England, there will always be people who value a physician's ethical tradition and the ability to treat both physical and mental problems. Thus, a demand for psychotherapy by psychiatrists will continue. Strain<sup>8</sup> pointed out that the psychiatrist who consults with his medical colleagues is often asked to deal with emotions, doctor-patient issues, and environmental issues. Without an understanding of psychodynamics and interpersonal interactions, the psychiatrist will be of limited value to his consultees. Dogherty and associates<sup>9</sup> warned that the subject-object relationship between doctor and patient, inherent in the medical model, is very different from the personalized subject-subject relationship of psychotherapy. Put another way, psychotherapy humanizes the patient and accentuates his unique individuality. A schizophrenic, for example, who fears losing his identity, may have his fears realized if in his relationship with his therapist he is treated like an object with a disease who needs pills. In other words, a totally organic approach to the patient will be antitherapeutic and lead to further ego disintegration. To adequately heal even the sickest of psychiatry's patients—the schizophrenics—one needs trust and humanism, in addition to medications. And schizophrenics are one group of patients virtually all prognosticators see as viable clients in psychiatry's future.

### Can the Marriage Be Saved?

Eisenberg<sup>10</sup> pointed out that psychiatry is in many ways similar to healing in primitive cultures. The shaman shares many characteristics with the psychiatrist. He stated that medicines alone are generally no cure for psychiatric illness; they merely diminish symptoms. "Brainless psychiatry," he asserted, is as bad as "mindless medicine." Rather than splitting psychiatry's functions by divorcing the biologic from the psyche, he spoke for a fusion in mind-body

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relationships. Psychiatry can provide a bridge between soma and psyche, but only if it encompasses both.

Yager<sup>11</sup> feels that human behavior is too complex to be treated from one point of view alone. A psychiatrist, in order to effect the best possible solution to a clinical situation, must know behavioral science, biology, and many types of therapy. Above all, the psychiatrist must be flexible so that he can choose from a variety of therapeutic possibilities. Lesse warned against the worship of "rating scales": over-objectification at the expense of teaching psychotherapy.<sup>12</sup> He feels psychiatry must move to a new level, by interrelating the psychobiological, psychodynamic and psychosocial into a total psychiatry. If this can be done, and if we do not cast off psychotherapy in our zest for neurobiology, the marriage can survive. Psychiatry must expand, not contract. And we in psychiatry must take pains to explain to our medical colleagues that psychotherapy, in tandem with the more "medical" aspects of psychiatry, has much that is unique and important to offer. An eclectic psychiatry, properly applied, can be beneficial to psychiatric and non-psychiatric patients alike.

Is divorce imminent? We must say yes. As Dogherty<sup>9</sup> clearly showed, combining a medical-objective and psychotherapeutic-subjective view of patients is a very difficult task. The pressures for separation are immense. But the benefits to mankind, if the marriage can be saved, are great. If psychiatry broadens, by keeping what it now has and expanding into newer areas, we will all be the better for it. But it will take a lot of work to keep the marriage together. I vote we try.

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## Antibiotic Prophylaxis of the Eyelids

THE LID MARGINS are waterproof. They shed tears, as we all know; they are covered with mybomian secretion and they resist antibiotics in an aqueous vehicle. So, for preoperative preparation, one must use an antistaphylococcal ointment.

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